DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/26/13

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445135	A. BUILDING _____ B. WING _____	09/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WINDWOOD	220 LONGMIRE RD CLINTON, TN 37716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED (F-441) During the annual recertification survey and complaint investigations completed on September 11,2013, at Golden Living Center-Windwood, no deficiencies were cited in relation to the complaints # 31729, # 29770, # 29816, #31129 and # 30169, under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000		
F 202 SS=E	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure documentation was available for four residents (#26, #94, #137, and #147) of twenty-eight discharged residents reviewed. The findings included: Resident #26 was admitted to the facility on May 15, 2013, and discharged on May 26, 2013,	F 202	F202 SS=E Residents Affected Residents # 26, #94, #137, & #147 were affected. Residents Potentially Affected All discharged residents have the potential to be affected. Measures/Systemic Changes A discharge summary was completed on each of the following residents: #24, #94, #137, and #147, signed by the resident's physician and placed in each of their respective discharged record. Licensed staff educated on this regulation. The discharging nurses of the 4 residents found not to have summary were counseled.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Underwood, Executive Director — TITLE — (X6) DATE: 9/25/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445135	A. BUILDING _____ B. WING _____	09/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WINDWOOD	220 LONGMIRE RD CLINTON, TN 37716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 202	Continued From page 1 Resident #94 was admitted to the facility on June 22, 2013, and discharged on August 19, 2013. Resident #137 was admitted to the facility on June 7, 2013, and discharged on July 12, 2013. Resident #147 was admitted to the facility on March 23, 2013, and discharged on May 13, 2013. Review of the residents' medical records revealed no documentation of a discharge summary for the residents. Interview with the medical records clerk on September 11, 2013, at 12:50 p.m., in the conference room, confirmed was no documentation of the residents' (#26, #94, #137, and #147) discharge summaries.	F 202	Monitoring Changes Charts of recently discharged patients will be brought to daily start up to ensure discharge summaries have been completed. If incomplete, supervisor will follow up until completed. Summary will be given to physician for validation and signature. Progress on timely completion of summaries will be reviewed at the Quality Assurance Performance Improvement Committee which includes: Director of Nursing, Executive Director, Assistant Director of Nursing, Registered Nurse Assessment Coordinator, Social Services, Medical Director and Dining Services. The committee meets monthly and will review progress reports for three (3) months and make recommendations as appropriate.	10/22/13
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain or enhance each resident's dignity and respect in three of sixty rooms observed. The findings included:	F 241	F241 SS=D Resident's Affected Resident in 310 and residents in two other rooms on same hall. Residents Potentially Affected All residents have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445135	A. BUILDING _____ B. WING _____	09/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WINDWOOD	220 LONGMIRE RD CLINTON, TN 37716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 Observation of Certified Nursing Assistant (CNA) #5 on September 9, 2013, at 8:50 a.m., in the South 300 hallway, revealed the CNA entered three resident rooms without knocking or asking permission to enter. Continued observation of CNA #5 revealed the CNA entered room 310 and began personal care for a resident without informing the resident what the CNA was going to do. Licensed Practical Nurse (LPN) #1 was also in the resident's room at the time of the incident. Interview with CNA #5 on September 9, 2013 at 8:55 a.m., in the South 300 hallway, confirmed the CNA did not knock on the doors of the residents' rooms. Interview with LPN #1 at the South Nurse's Station on September 9, 2013, at 9:05 a.m., confirmed CNA #5 did not inform the resident before personal care was started. Interview with the Director of Clinical Education on Sept 10, 2013, at 2:15 p.m., in the small dining room, confirmed all employees are supposed to knock on a resident's room door before they enter. Continued interview confirmed the CNAs are supposed to inform the resident of the care they are going to be doing before beginning care.	F 241	<u>Measures/Systemic Changes</u> CNA #5 and Nurse #1 were counseled one on one and required to complete Resident Rights USS-19000 on Golden University and pass quiz with results placed in their personnel files. Staff in-serviced regarding dignity and respect <u>Monitoring Changes</u> The Director of Nursing, Assistant Director of Nursing, and Unit Manager will randomly observe staff members providing care to residents weekly over the next 3 months and provide immediate re-training if needed. The results of the observations will be reviewed at the Quality Assurance Performance Improvement Committee which includes: Director of Nursing, Executive Director, Assistant Director of Nursing, Registered Nurse Assessment Coordinator, Social Services, Medical Director and Dining Services. The committee meets monthly and will review the audit observations for three (3) months and make recommendations as appropriate.	10/22/13
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both	F 242	<u>Residents Affected</u> Resident #93 was affected. <u>Residents Potentially Affected</u> All residents have the potential to be affected.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445135	A. BUILDING _____ B. WING _____	09/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WINDWOOD	220 LONGMIRE RD CLINTON, TN 37716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 3 inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to accommodate a resident's choice of breakfast for one resident (#93) of eight residents observed in the enhanced dining area. The findings included: Medical record review of resident #93's Minimum Data Set (MDS) dated August 1, 2013, (quarterly review) revealed the BIMS (brief interview for mental status) score was 15 (13-15 means cognitively intact). Observation on September 9, 2013, at 7:20 a.m., in the enhanced dining area, revealed eight residents were seated, with two staff members serving the trays. Continued observation revealed certified nursing assistant #3 (CNA) served a tray to resident #93. Continued observation revealed the resident was served scrambled eggs; and the resident requested fried eggs instead of scrambled eggs. CNA #3 stated would try to get the resident the fried eggs. Continued observation revealed CNA #3 finished serving the trays in the enhanced dining and went to serve trays in the main dining area, without requesting the fried eggs. Continued observation revealed resident #93 finished breakfast at 7:40 a.m., leaving the scrambled eggs uneaten. Interview with CNA #3 on September 9, 2013, at	F 242	**Measures/Systemic Changes** **Resident #93 gets selective menus and his desire for fried eggs instead of scrambled is noted on his food preferences. If changes are desired after selecting menu, Dining Services Director will meet with resident to resolve. Resident's care plan has been updated to reflect that at times resident requests items at mealtimes that were not option on selective menu. If this resident or others have special requests at mealtimes, servers will communicate this to dining services and they will fill requests at tray line breaks. Residents who are able and desirous will participate in selective menus and every reasonable effort will be made to accommodate choices. Staff in-serviced regarding server/dining services communication of accommodation of resident preferences.**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445135	A. BUILDING _____ B. WING _____	09/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WINDWOOD	220 LONGMIRE RD CLINTON, TN 37716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 4 7:47 a.m., in the main dining room, confirmed did not accommodate the resident's request of fried eggs.	F 242	**Monitoring Changes** **Restorative CNAs will monitor for accommodations of resident preferences during meal times and intervene as necessary to ensure follow up. Issues noted will be communicated to Lead CNA or Dining Services Director as appropriate for follow up. Food Council meetings will be held biweekly by Dining Services Director/Assistant X 2 months then monthly thereafter with all residents invited to attend and offer input on food selections. Minutes of meeting and results of the observations will be reviewed at the Quality Assurance Performance Improvement Committee which includes: Director of Nursing, Executive Director, Assistant Director of Nursing, Registered Nurse Assessment Coordinator, Social Services, Medical Director and Dining Services. The committee meets monthly and will review the audit observations for three (3) months and make recommendations as appropriate.**	10/22/2013
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445135	A. BUILDING _____ B. WING _____	09/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WINDWOOD	220 LONGMIRE RD CLINTON, TN 37716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 5 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and interview, the facility failed to maintain standard infection control practices during the ice pass for one of six hallways and failed to wear gloves during a finger stick for glucose monitoring for resident #10. The findings included: Observation on September 9, 2013, at 6:48 a.m., revealed Certified Nurse Assistant (CNA) #1, passing ice on the 100 Wing Hallway. Continued observation revealed the CNA entered three rooms, brought the resident's ice pitchers outside the room, took a scoop and filled the dirty ice pitchers with the ice pitcher over the opened ice chest. Continued observation revealed the CNA took the ice pitchers back into the resident's rooms, exited the room and continued the ice pass. Interview with CNA #1 on September 9, 2013, at 6:55 a.m., in the 100 Wing Hallway, confirmed the CNA filled the dirty ice pitchers with ice over the opened ice chest. Review of facility policy, Handling Ice, with no date, revealed " ...ice for consumption will be handled in a manner to avoid cross contamination	F 441	**Residents Affected** **Residents on 100 hallway and resident #10 were affected.** **Residents Potentially Affected** **All residents have to potential to be affected.** **Measures/Systemic Changes** **One on one was conducted with CNA #1 covering correct procedure for passing ice. One on one with LPN#4 on proper procedure for finger-sticks and using sharps container. Nursing staff in-serviced regarding infection control guidelines.** **Monitoring Changes** **Observation on clinical rounds as well as non-clinical rounds to ensure policies are followed. Director of Nursing, Assistant Director of Nursing, Unit Manager and Director of Clinical Education will randomly observe finger sticks on clinical rounds 2 x weekly for one month then weekly for 2 months with immediate staff re-training if necessary. Reports of observations will be discussed in Quality Assurance Performance Improvement X 3 months and plans revised as needed.**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445135	A. BUILDING _____ B. WING _____	09/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WINDWOOD	220 LONGMIRE RD CLINTON, TN 37716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 6 ..." Interview with the Director of Nursing (DON) on September 9, 2013, at 8:15 a.m., on the 100 Wing Hallway, confirmed the CNA failed to follow facility policy and failed to ensure cross contamination did not occur. Observation on September 11, 2013, at 10:55 a.m., in resident #10's room, revealed Licensed Practical Nurse (LPN) #4 performing a finger stick for glucose monitoring for the resident and was not wearing gloves. Continued observation revealed the LPN completed the finger stick, exited the room, and placed the lancet device in the biohazard box with no gloves on the hands. Review of policy, Obtaining a Drop of Blood, with no date, revealed, " ...wash hands, inform person being tested what you are going to do, provide privacy, and put on gloves ..." Interview with LPN #4, on September 11, 2013, at 10:56 a.m., outside of the resident's room, confirmed the LPN performed the finger stick for glucose monitoring on the resident and failed to weargloves during the procedure. Interview with RN #1, on September 11, 2013, at 11:00 a.m. in the main entrance hallway, confirmed the LPN failed to follow facility policy related to wearing gloves.	F 441	**Registered Nurse Assessment Coordinator/Social Services Director/Health Information Manager will observe ice pass on non-clinical rounds 2 x weekly for one month then weekly for 2 months with immediate staff re-training if necessary.** **The results of the observations will be reviewed at the Quality Assurance Performance Improvement Committee which includes: Director of Nursing, Executive Director, Assistant Director of Nursing, Registered Nurse Assessment Coordinator, Social Services, Medical Director and Dining Services. The committee meets monthly and will review the audit observations for three (3) months and make recommendations as appropriate.**	10/22//2013